Newark Community Project for People With A.I.D.S.

'Let us fight the virus, not each other.'

P.O. BOX 1241, Newark, N.J. 07101

8 May, 1989

Mr. Robert Sabreen
Office of the Assistant Regional Director
Division of Youth & Family Services
N.J. Department of Human Services
1100 Raymond Boulevard, 18th Floor, Suite A
Newark, New Jersey 07102

Dear Mr. Sabreen:

I am herein transmitting the revised plan of the Newark Community Project for People With A.I.D.S. (N.C.P. for PWAs) Adolescent Outreach Counseling Program which has been prepared in close consultation and cooperation with Dr. Adewale Troutman, Medical Director for the City of Newark (please note his letter in Appendix C so attesting).

The broader consultative process has taken longer than anticipated, but we believe the end product is the better for the effort. Clearly, one of this program plan's major inherent strengths lies with the network of communication, cooperation, and coordination we anticipate, all in conjunction with the lead role assumed by the Medical Director. We believe this is the only rational way to address the myriad of problems confronting us here in Newark.

We believe this program plan, after several revisions and updates, now meets the additional needs you articulated last month: (1) Priority, for those adolescents and young adults targeted for intensive counseling in the post Summer '89 period, will be given selected D.Y.F.S. referrals; (2) Provision has been made for additional group presentations to an estimated 400 cases in the post Summer '89 period, arrangements for which shall be accomplished in close consultation with D.Y.F.S.; (3) The substance of the training program for the peer counselors, the significant points to be stressed in group presentations, and the objectives of the follow-up one-on-one counseling and tracking activities (along with specific time frames) have

all been outlined herein; (4) The three supervisory positions have been described; (5) A brief description of the research and evaluation model has been provided; and (6) The N.C.P. for PWAs budget for $100,000 of DYFS funding and $8,000 of Prudential Funding (through December 31st only) has been set out along with the written commitments of Dr. Troutman of an additional $130,000 - plus (minimum one-third time of City A.I.D.S. Coordinator).

In the interim, the volunteer time we were able to devote to updating and enhancing this program plan was interrupted by the necessity to respond to an RFA (RFP) from the Department of Health for a directly complimentary plan. Should this latter plan become a reality, we would, in conjunction with the City Medical Director, be able to add six (6) adult year-round counselors to the overall program and thus enhance the decentralized portion of the supervision and intervention procedures. We are hopeful that Health Department officials will appreciate the urgent need for a more coordinated approach as this overall program plan promises.

There are also additional promising prospects on the horizon (VISTA Volunteers, CDC grants, Robert Wood Johnson Foundation drug abuse education/prevention efforts, etc.) with which we are intimately familiar. Should some or all of these efforts bear fruition, the opportunity for a much more concerted and widespread attack on the problems we confront could be mounted, building on the coordinated network we are all now in the process of establishing -- at long last.

Your initiative, advice and counsel, and continuing support have been much appreciated.

With Sincere Regards

Derek T. Winans
Chairperson

c.c. Dr. Adewale Troutman
Dr. Robert Johnson
Dr. George Jackson
Mr. Urbano Venero
N.C.P. for PWAs Executive Committee
Members, Task Force Co-Chairs, & Friends
Mr. Timothy Weeks
Mr. Frederick Waring

THE NEWARK COMMUNITY PROJECT FOR PEOPLE WITH A. I. D. S.

ADOLESCENT OUTREACH COUNSELING PROGRAM

(In conjuction with the City of Newark, (Departments of Health and Human Services and Manpower Training), and in coordination with The Adolescent Medicine Department of the University of Medicine and Dentistry of N.J., the Office of the N.J. Coordinator, National Associaiton of Black Psychologists, the La Casa de Don Pedro - PROCEED Task Force on AIDS, SPECIAL AUDIENCES, and other community organizations, and coalitions of community organizations in Newark.)
(7 April - Rev. 4-26, 4-27, 5-4, 5-5, and 5-6-89)

I. INTRODUCTION

The Acquired Immune Deficiency Syndrome (A.I.D.S.) has the potential to be the most devastating killer in human history as recorded. In many parts of the nation its rate of increase has been nearly geometric. Until recently, very little attention was given to the fact that the adolescent population of the nation may constitute the specific age cohort with the highest risk factors for contracting the HIV infection, giving rise to the inordinately high numbers of people with AIDS in their late 20's and early 30's.

The readers of New Jersey newspapers know a great many things about People with AIDS. They know that residents of our State who are afflicted with AIDS disproportionately reside in Newark (1,864 cases in Essex as recently published). They know that People with AIDS in N.J. die disproportionately in Newark. They know that N.J. children born with AIDS disproportionately come from Newark. Today and virtually everyday in Newark hospitals there are 150 or more People with AIDS.

Although more slowly than seems warranted, the State is now beginning to respond to the realities of the situation. Authorities had, perhaps, hoped that because of the sources of the problem, it would be temporary and, therefore, would not require a permanent commitment of resources and a long term planning approach. It is now clear that we will need to create the kind of facilities in Newark and the coherent

coordinated planning processes that exist in other cities across the nation with significant populations of People with AIDS. New Jersey and Newark have to catch up, especially in reaching out to the adolescent high risk population.

This proposed plan envisions a broad range of activities designed to provide adolescents with a structured education/prevention program that uses a network of community organizations to deliver high quality counseling and informational sevices to the target population. Services will be provided through trained peer group counselors and through professionals sensitive to the cultural needs of the targeted adolescents. (Especially those for whom a bi-lingual, bi-cultural mode would be most appropriate).

The major purposes of this program proposal are to increase the accurate knowledge of AIDS and the HIV virus possessed by Newark adolescents, to identify and overcome attitudes which may be obstacles to adolescent rationality about AIDS and the HIV virus, and to reduce the extent of behavior which has been associated with the high risk of becoming infected by the HIV virus.

Our working hypothesis is that by effective intervention with youth, the projected growth in actual AIDS cases associated with City residence in the next decade, and beyond, can be appreciably slowed.

An explicit secondary purpose of the proposal is to add to the creation in Newark of a high degree of coordinated planning and activity in addressing the HIV epidemic. At the present time there are a significant number of relevant and sound programs and activities, funded from different State and Federal agencies as well as from some private foundations which are not effectively coordinated. In this epidemic situation, the high risk behavior by concerned agencies of redundancy, inefficiency, and lack of accountability cannot be tolerated.

The absence of a planful approach to the multi-faced crisis currently confronting us here in Newark which could yield a network of communication, cooperation, and coordination among service providers serious about addressing the AIDS epidemic is a definite hindrance. This plan is based on just such a planful approach yielding coordinated implementation strategies.

For that reason, we are seeking to bring together all those committed to combating the spread of the HIV virus and fostering the humane care and treatment of those afflicted or affected by the disease in Newark in order to effectuate just such a service-oriented network which can most

effectively work in conjuction with the Newark AIDS Consortium (Newark Hospitals), the City Medical Director's office (A.I.D.S. Coordinator), UMD-N.J.'s Adolescent Medical Department, the N.J. AIDS coordinator for the Association of Black Psychologists, The La Casa de Don Pedro - PROCEED A.I.D.S. Task Force, SPECIAL AUDIENCES, and any and all others seriously interested in resolving the problems. It is for this reason, too, that the AIDS Coordinator for the City of Newark's Health & Human Services Department will be the responsible lead administrator of this program, even though funds for that position are not to be paid our of funds requested in this proposed program plan.

[See appendix for a Description of the Target Population and Needs Assessment with attached reprint of cover story from 3 April 1989 issue of 'Insight' magazine.]

II. ORGANIZATION IDENTIFICATION

The Newark Community Project for People With A.I.D.S., Inc. (N.C.P. for PWAs) is a non-profit coorporation organized into an action - oriented network of representatives from different entities and individuals serious about confronting the AIDS crisis in order to focus on the community's current AIDS crisis. The organization curently envisions creating a program of HIV/AIDS prevention for the City of Newark (with emphasis first on at-risk adolescents) and subsequently for Newark environs as well.

The Mission Statement of The N.C.P. for PWAs states, in parts, that:

"The purpose of the N.C.P. for PWA's is to foster the humane care and treatment of people with AIDS and ARC and to work to prevent the spread of the disease."

The organization's leadership is largely made up of people already active in a number of Newark's existing organizations. The Board of twelve is 83 percent Minority (Nine Black, two White, one Hispanic). Many of the individual Board members and all of the Task Force Co-chairs are affiliated with and have played prominent, leadership roles with programs and organizations that have 'clear' records in delivering services in the City of Newark.

These include such organizations as United Hospitals, the Urban League, the New Jersey Commission on the Blind and Visually Handicapped, the Newark Free Public Library, Rutgers - the State University in Newark, the Newark Boys and Girls Clubs of America, the Newark Coalition for Neighborhoods, Planned Parenthood of Essex County, The Central Ward Coalition of Youth Agencies, the Newark Tenants' Council, Protestant and Catholic Churches (Black,

White, and Hispanic) the International Youth Organization, and various drug rehabilitation and prevention programs (Soul-O-House, La Casa, et al).

In addition, both directly and indirectly (through participating community-based organizations and coalitions of such organizations), N.C.P. for PWAs maintains on-going close working relations with the Youth Aid Bureau of the Newark Police Department; with the Family Crisis Intervention Unit (F.C.U.I.) of the Essex County Division on Youth, Department of Citizen Services; UMD-N.J. (both C.M.H.C. and Adolescent Medicine); and, of course with staff at all levels (District, Regional, and State) of the N.J. Division of Youth and Family Services (DYFS), Department of Human Services.

Hence, the network's contact with runaways, with homeless, and - indeed - with most all of the vulnerable adolescents of our City is extensive. [In fact, we do not really believe the problem in our City lies in locating and identifying 'street' adolescents, but rather with the services provided them and, even more important, with the follow-up contact maintained therafter. [This is in contrast to the usual 'information and referral' run-around these youth have often experienced in the past.]

The organization is inclusive by nature, welcoming all representatives of organizations, institutions, and agencies as well as individual activists who are serious about fostering the humane care and treatment of people living with A.I.D.S. and combating the spread of the HIV infection. We seek to operate by concensus to avoid diviseness or competition.

III. PROGRAM PLAN:

This program envisions a broad range of activities designed to provide adolescents with structured and pre-planned education/prevention efforts that use a network of community organizations to deliver high quality counseling and informational services to the target population. Services will be provided through trained peer group counselors and through professionals sensitive to the cultural needs of the targeted adolescents.

These direct services will include, but not be limited to exposure, orientation, and initial educational activities (usually in group settings), and individualized counseling, and tracking activities (usually in one-on-one settings).

This program will function in close coordination with the Newark Department of Health and Human Services, the Newark Summer Youth Employment and Training Program (SYETP),

the Department of Adolescent Medicine of the University of Medicine and Dentistry of N.J., and the Office of the New Jersey A.I.D.S. Education/Prevention Coordinator for the Association of Black Psychologists, the La Casa de Don Pedro - PROCEED Task Force on AIDS, drug rehabilitation and prevention programs, and others. The Office of the City of Newark's Medical Director will take the lead role in this combined effort. Indeed, the degree of communication, cooperation, and coordination envisaged by this planned program constitutes one of its most signficant inherent strengths.

The Newark Adolescent Education/Prevention program will operate in four phases: (A) Planning and Start-up; (B) Summer '89: Exposure, Orientation, and Initial Educational Efforts; (C) Counseling and Tracking; Data Collection; and (D) Data Analysis, Program Evaluation. Even though these phases are broken out into rough time frames, the activities envisaged may not be quite so discreet; indeed, some may overlap.

TIME FRAMES

PRE PLANNING AND START-UP	Summer '89: Exposure, Orientation, Initial Education, Etc., (Staff Training)	Counseling, Tracking, Etc., Data Collection	Follow-up,	Data Analysis & Evaluation
4/1/89	6/23	9/1	5/1/90	6/30

A) Phase I: Planning and Start-Up

In this phase, we will seek to accomplish those tasks necessary to ensure the smooth operation of the program as a whole. These include the following:

1. Recruitment and hiring of full time staff.

2. Logistical arrangements with SYEPT (locations, scheduling, and some training of its staff).

3. Establishing program sites (CBOs, etc.).

4. Acquisition of equipment which includes the van and some office materials.

5. Development of training curriculum for peer counselors in conjunction with Dr. Robert Johnson and Dr.

George Jackson, the La Casa de Don Pedro - PROCEED Task Force, and the Newark Medical Director.

6. Development of standard groups presentation outline in conjunction with Drs. Johnson and Jackson, the La Casa de Don Pedro - PROCEED Task Force, and the Newark Medical Director.

7. Recruitment and hiring of peer counselors.

Also, in this phase specific plans for developing and collecting data as to participant profiles (including peer counselors), pre - and post examinations, relevant behavior pattern changes, etc, will be completed. Research will be intensified on an on-going basis as to previous studies, e.g., 'AIDS Knowledge and Attitudes for September, 1988' published by the U.S. Public Health Service; the 'National Adolescent Student Health Study', excerpts from the results for which were first released in late 1988; results of 'A Recent Survey in New Jersey of Public School Students' referenced recently by Mr. Octavius Reid, Jr., Executive Director of the New Jersey School Boards Association; and others; as well as such on-going studies (as yet unpublished) as the Rutgers University Institute for Health Care Policy and Aging Research study on Newark School Drop-outs; Dr. Robert Johnson's study on Newark Adolescent Attitudes and Behavior Patterns; the Equitable Life Assurance Study on Major Cooporate Employees' Knowledge and Attitudes; and others. [See Appendix B for References.]

Results of our own critical reviews of these and related studies should be of assistance in framing the data collection phase as well as the data analysis itself [See Phase IV discussion of Data Analysis and Evaluation - Future Targeting.]

B) Phase II: Summer '89: Exposure, Orientation & Initial Educational Efforts

This phase will provide AIDS prevention/education sessions and presentations (in group settings) to SYEPT participants aged 14 to 21 years. The sessions will be presented at selected work locations throughout the City of Newark.

The group presentations will be held with an estimated 80 percent of all the currently slated 3,000 Newark Summer Youth Employment participants (including Summer Education/ Enrichment enrollees), or 2,400 unduplicated individuals. Based on past experience, the heavy majority of these will be among the lower portion of the age range. Some participants at those job sites with fewer enrollees may be

transported to another nearby site to receive the presentation.

These sessions will generally highlight such topics as: AIDS as a societal problem; The ways in which AIDS can and cannot be contracted; Methods of prevention that include, but are not limited to, abstinance from sexual intercourse and from the use of illicit drugs; and the symptoms and effects of A.I.D.S. More specific elements of the curriculum will generally follow the 'Guidelines for Effective School Health Education to Prevent the Spread of AIDS' as prepared by the U.S. Centers for Disease Control (C.D.C.) of Atlanta, Ga., (MMWR Supplement).

The standard presentations for these sessions will be developed by the trainers/presenters in ways that are sensitive to the cultural needs of the targeted groups (especially including bi-lingual bi-cultural modes). [An integral part of all training and all presentations will include emphasis on values inherent in the cultural spiritualism endemic to the communities to be addressed.] The 21 peer group counselors will receive presentation training and will view the SPECIAL AUDIENCE's Teen-to-teen A.I.D.S. production, some pertinent films, and relevant brochures, flyers, etc.

Training for peer counselors will occur during the first week of the Summer phase. This training program will be designed, developed, and conducted under the supervision of the Adolescent Medicine Department of the University of Medicine and Dentistry of N.J., the N.J. A.I.D.S. Coordinator for the National Association of Black Psychologists, the La Casa de Don Pedro - PROCEED Task Force, and others, all in conjuction with the Newark Health Department. Generally, the curriculum will include, but not be limited to: (1) interviewing techniques; (2) up-to-date information about AIDS; (3) presentation skills; (4) client problem identification; (5) case monitoring; and (6) record keeping. [Some transportaion via the van may be necessary to accomplish those objectives.]

Also during the Summer portion of the program, a coordinated effort will be made to target, for special attention and follow-up efforts, approximately 340 of the 2,400 (15 percent of these participants) who exhibit the following characteristics (not necessarily exclusive of each other):

a) Existing D.Y.F.S. cases and subsequent D.Y.F.S. referrals,

b) Participants who reside in households with current or past substance abusers or who have older nuclear family members with such a history,

c) Referrals from the Family Courts,

d) Those who volunteer information regarding substance abuse or homosexual behavior,

e) Handicapped/Disabled youth who share one or more of the above characteristics, and

f) School drop-outs.

(It should be noted that much of this information, if and when obtained, must be maintained in a strictly confidetial manner, inaccordance with Federal regulations.)

Although follow-up efforts will be concentrated in the third phase, some cases may require immediate attention and will be treated during the second phase.

C. Phase III: Counseling and Tracking Data Collection

Following completion of the Newark SYEPT program, N.C.P. for PWAs staff, in conjuction with City Staff -- teen peer group leaders in particular, with the assistance of such adult counseling staff from the host agency as is available -- will reach out in each of their respective neighborhoods to seek contact with other youth, especially those unemployed and out of school (non-graduates). These idle youth, often found 'hanging out' on street corners, in video parlors, or adjacent to abandoned buildings and, in the words of Ms. Carolyn B. Thompson - Wallace, Executive Director of the International Youth Organization (I.Y.O.), "whose only sense of purpose in life appears to be instant gratification," also constitute an inherently high risk population for the HIV infection.

The follow-up portion of this phase will require one on one contact with members of the targeted group. Based on past experiance, we estimate that the specially targeted population will amount to approximately 15 percent (340) of the approximately 2,400 SYEPT participants we will reach in the Summer phase of this program.

Priority for follow-up type services will be given to referrals from DYFS. In addition to the 340 SYEPT participants, we estimate that about 400 additional referrals will be made from DYFS and, of these, approximately 80, or 20 percent, will require more intensive follow-up counseling, yielding a total of 420 unduplicated individuals.

Based on this estimate, eleven peer counselors will be working 12 hours per week, seven (7) paid by Newark Health Department (funded by N.J. Department of Health) and four (4) will be paid by N.C.P. for PWAs out of DYFS funding.

Day-to-day Supervision will be provided at two levels: (1) A Peer Counselor Supervisor will be retained by the City Medical Directors from D.O.H. funds already provided; and (2) A Chief Outreach Counselor will be retained by N.C.P. for PWAs from DYFS contained in the budget herein. The lead role for policies and procedures will be assumed by the Newark A.I.D.S. Coordinator, retained by the City Medical Director's Office (see letter from Dr. Troutman in Appendix c).

In the aggregate, the caseload of 420 will be divided into three categories:

1. About 84 individuals, or 20 percent, will require intensive counseling, or at least three (3) one-on-one peer counseling sessions of 45 minutes each per month, yielding a minimum schedule per counselor of --

-84 individuals times 3 sessions, or a total of 252 such sessions, divided by eleven (11) peer counselors, equals:

17.25 hours per month.

2. About 252 individuals, or 60 percent, will require average counseling, or at least one (1) one-on-one peer counseling session of 45 minutes each per month, yielding a minimum schedule per counselor of --

-252 individuals times one session, or a total of 252 such sessions, divided by eleven (11) peer counselors, equals:

17.25 hours per month.

3. About 84 individuals, or 20 percent, will need minimal counseling, or at least one-on-one peer counseling session of 45 minutes per session every other month, yielding a minimum schedule per counselor of --

-84 individuals times 1/2 session, or a total of 42 such sessions per month, divided by eleven (11) peer counselors, equals:

2.85 hours per month.

TOTAL COUNSELING TIME PER MONTH: 37.35 hours per month.

Since the average month will yield about 51.6 paid hours per month (12 x 4.3 weeks per average month), each peer counselor will have about 14 hours and fifteen minutes per month remaining for telephone calls, additional in-service training, some paper work, travel, and related functions. (It maybe necessary for the chief outreach worker to accompany the peer counselors in the van to a given

encounter session in order to furnish needed technical assistance and related services.]

Besides the one-on-one peer counseling sessions, the approximately 420 targeted individuals will be followed via telephone calls and mail.

Because it is suspected that a substantial number of the targeted group may remain reluctant to adopt behavior that could eliminate their risk of becoming infected, one-on-one, face-to-face counseling activities will stress preventive behavior that should be practiced by these participants at increased risk. These include: avoiding sexual intercourse with anyone who is known to be infected, who is at risk of being infected, or whose HIV infection status is not known; using a latex condom with spermicide; not sharing needles; and seeking treatment for drug addiction.

In addition, targeted individuals will be incouraged to develop and maintain affiliations with some youth service organization and, where necessary, to return to school or enter a positive alternative program (job training, GED, military enlistment or, at least, obtain a job).

Some psychological services may be needed for individual participants or the participants and family member(s) together. While CMHC and other institutions can sometimes provide these services, our experience has been that an inordinate proportion of these clients do not return for follow-up sessions in these institutional settings. Rather, those who are prepared to accept such services much prefer that the services be provided at a local site, within the neighborhood, usually on the premises of a local communiy-based organization.

Fortunately, the N.C.P. for PWA's network includes the N.J. AIDS Coordinator for the Association of Black Psychologists, Dr. George Jackson, whose extensive experience with DYFS referrals, IYO clients, and others as well as his known research in the pathology of substance abuse (and its association with anti-social behavior patterns) makes him eminently qualified to assist in this program.

Finally, it should be noted that the N.C.P. for PWA's network, in conjunctiin with the City Health Department and the Newark Coalition of Neighborhoods (N.C.N.), plans a massive and comprehensive effort to combat drug abuse throughout the City. In the meantime, N.C.P. for PWAs is negotiating with N.J. VISTA/ACTION to place a number of VISTA Volunteers at each of the seven existing drug clinics who would perform outreach counseling functions targeted to adolescent 'street youth' in conjunction with this program

(similar training, orientation, initial education, etc.) Results from two different demonstration projects, one slated for a consortium of a drug rehab/prevention clinic, a youth services agency, and a day care center with extraordinarily young parents, and the other targeted to deal with 11-to-13 years olds alone during Summer '89 ought to provide us with valuable experience and some baseline data.

D) Phase IV: Data Analysis; Program Evaluation

As indicated above, there are three 'universes' from which we expect outcomes. While the outcomes will be different from group to group, all are dependent for assessment upon the creation of relevant data bases which are sensitive to confidentiality needs and requirements. No data not essential to the planned program evaluation will be collected (except for data readily available and necessary from S.Y.E.P.T., D.Y.F.S, etc.)

The evaluation of the cadre of peer counselors is, we believe, relatively straightforward. It rests first upon the demonstration that these counselors have in fact acquired a fund of accurate knowledge about AIDS and sources of information about AIDS which is essential to their successful assistance in implementing the project as a whole.

The program plans to test counselors as to the extensiveness of their knowledge and of the project's ultimate goals. Just as importantly, their ability to find answers to questions that may be raised during their outreach efforts (coupled with the wisdom to say 'No, I don't have the answers but will try to find out') will also be tested prior to their actual counseling.

A high standard of demonstrated success in acquiring knowledge will be required before allowing any interaction with the larger 'client groups.'

We intend to evaluate the second universe, i.e. the approximately 2,400 Summer program enrollees on their knowledge and attitudes. This will be accomplished by collecting a limited amount of identification and demographic data from all participants (name, telephone, gender, ethnicity, age, educational level, et al) no later than the time of their first session. A random sample (of about 400 such participants), which promises a high degree of representativeness, will be drawn from this group and that sample will be contacted and surveyed by telephone. Most questions for this telephone survey will be drawn from the National Health Interview Survey of AIDS Knowledge and Attitudes, The National Center for Health Statisitics, Public Health Service, U.S. Department of Health and Human

Services. We do not envision using the complete survey, but intend to focus upon questions where the national sample seemed to indicate the weakest knowledge among adolescents. Our goal is to have these Newark Adolescents at least exceed the knowledge and attitude levels shown by adolescents in this national survey. [This effort, like all others, will be conducted in a bilingual, bi-cultural mode.]

The third universe, that of the high risk group, is the most sensitive because fuller data will need to be collected and because the objective is not just to increase knowledge and improve attitudes, but to change behavior patterns.

Consistent with relevant Federal or State research protocols and based upon consultation with relevant agencies, a very full 'client' data base will be collected, verified, and maintained. We envision this will include all standard demographic variables rather than the limited information we will collect for the larger group, a record of counsleor contacts, and the basis for initial identification as a potential at-risk case. A behavior assessment instrument for the use of the counselors will be developed to provide an on-going record of either change or inertia. We envision the creation of aggregate cross-tabulations based upon this data, which should be useful in program planning for the future.

However, the true measures of success will in fact be individual. With due respect for confidentiality problems, we would anticipate reporting not only any aggregate measures which seem important, but, more importantly, 400 assessments of behavioral change and societal affectiveness based upon individual histories. No doubt, patterns may emerge from these assessments, but it is the individual assessment, similar to that done by any supportive family of a developing adult, that is the goal of our evaluation program.

IV. RESULTS OR BENEFITS EXPECTED

1) It is anticipated that through the peer counselors, the program will have provided direct (either one on one or group) AIDS education/prevention information to at least 2,800 Newark adolescents.

2) It is anticipataed that follow-up procedures with 420 adolescents will:

-Identify those adolescents suffering from psychological and social pressures which may require direct counseling (psycho-social or other therapeutic modes as needed).

-Encourage adolescents to develop and maintain affiliations with some youth service organization, e.g, Boys and Girls Club, International Youth Organization, etc.

- Assist in tracking certain types of behavior (drug abuse etc.) and seek to persuade the adolescent to enroll in appropriate rehabilitation program.

-Encourage drop-outs to return to school or enter a positive alternative program (Job training, GED, military enlistment, or at least obtain a job).

3) It is anticipated that data will be obtained that will allow the identification of education/prevention needs that are unique to the handicapped/disabled.

4) It is anticipated that data collection will assist in filling in gaps in the currently inadequate Newark database.

5) It is anticipated that 15,000 pieces of AIDS prevention/education literature will be distributed to adolescents.

6) It is anticipated that the peer group counsellors will gain confidence and a sense of self esteem that will enhance leadership capabilities (to be tested with pre and post self image tests developed by Dr. Jackson in consultation with Dr. Johnson and implemented under Dr. Jackson's supervision).

NEWARK ADOLESCENT AIDS PREVENTION PROJECT
N.C.P. For PWAs
Budget (4/1/89 - 6/30/90)

	PROGRAM PLAN (D.Y.F.S.)	PRUDENTIAL FOUNDATION (4-1 Thru 12-31-89)	TOTAL
I PERSONNEL			
A. Salaries & Wages			
1. Admin/Researcher (50%)	13,959	-0-	13,959
2. Trainer/Chief Outreach Couns.	13,332	-0-	13.332
Sub-Totals, S&W (f/T)	27,291	-0-	27,291
B) Fringe Benefits at 17.61% .	4,806	-0-	4,806
C) Salaries & Wages (P/T) 21 Peer Counselors, (15 hrs/wk in Summer, 12 hrs/wk post Summer)	17,676	-0-	17,676
D) Fringe Benefits at 11.35%	1,982	-0-	1,982
Totals All Personnel	51,755	-0-	51,775
II COUNSULTANTS & PROFESSIONAL FEES			
A. Audit Fees		500	500
B. Acct./Bookg. Services	500	300	800
C. Presenters, Trainers, Psychologists, etc.	2,300	-0-	2,300
D. Clerical/Services	500	2,846	3,346

	PROGRAM PLAN (D.Y.F.S.)	PRUDENTIAL FOUNDATION (4-1 Thru 12-31-89)	TOTAL
E. Research, Planning & Evaluation	2,500	500	3,000
Total	5,800	4,146	9,946
III CONSUMABLE SUPPLIES	0		
A. Education/prevention Materials	2000		20000
B. Office Supplies (including Computer software)	3118	500	3618
TOTAL	5,118	500	5618
IV TRAVEL			
A. At $.24/mi.	800	200	1000
B. Oil, Gas & Repairs	1800		1800
C. State Health Dept. Conference (Preventive 89')	1800	1800	3600
D. Vehicle Insurance	1500	-0-	1500
TOTAL	5,900	2,000	7,900
V. EQUIPMENT			
A. 12-15 Passenger Van	19,000		19000
B. Lease of off. Eqt. (copy machine, word processor, printer, etc.			
TOTAL	22,458	-0-	22,458

	PROGRAM PLAN (D.Y.F.S.)	PRUDENTIAL FOUNDATION (4-1 Thru 12-31-89)	TOTAL
VI SPACE			
A. RENT	2250		2250
B. UTILITIES	564		564
C. LIABILITY INSURANCE	594		594
SUB-TOTAL	3408	-0-	3408
VII OTHER COSTS			
A. PRINTING & DUPLICATION	2000	754	2754
B. TELEPHONE	1561	100	1661
C. POSTAGE	2000	500	2500
TOTAL	5,561	1354	6915
GRAND TOTAL	$100,000	8,000	108,000

Note 1: This budget does not include other contributions already committed from the City of Newark ($130,000 plus one-third of City A.I.D.S. Coordinator) specified in letter of support from Dr. Troutman (contained in Appendix C.)

Also, this budgetary presentation contains no mention of the considerable in-kind support (staff assistance, computer time, space, etc) to be contributed by the City Manpower Department, the City's anti-poverty program, and so many other institutions, organizations, and associations committed to assist this unified effort.

Note 2: Of the total 21 peer group counselors, working during Phase II of the Project (Summer '89), seven are to be retained by the City Medical Director's Office. After September, 11 peer counselors will be retained, for by N.C.P. for PWAs and seven by City.

APPENDICES

A. Statement of Need & Target Population Description with Relevant Excerpts, from 'Insight' Magazine, 3 April, 1989.

B. References to Prior and On-going studies Pertinent to This Project.

C. Supplementary Budget Informational Letters of Support from Dr. Adewale Troutman and Mr. Richard Matthews.

APPENDIX A

DESCRIPTION OF THE TARGET POPULATION AND NEEDS ASSESSMENT

Some background data about the City of Newark itself is important to understand the dimensions of the problem.

The Census of 1980 and the State and Metropolitan Area Data Book give a clear picture of how different Newark is from the rest of its own SMSA as well as from all other central cities of the nation.

Newark has the highest proportion of residents living below the poverty level than any other major City in the nation. The City's Black and Hispanic population, constituting a signficant majority of all residents, comprises an inordinate share of those living in poverty. Recent data suggest that this situation has worsened.

Of Newark's residents between the ages of 16 and 21, fifty-four percent were not in school, compared to 23 percent of school drop-outs in the rest of the SMSA. Only 45 percent of persons 25 years and older had graduated from High School compared to 74 percent in the rest of the SMSA and 65 percent of national central city populations. Only 6.3 percent of residents over the age of 25 had 16 years or more of education; this low educational attainment made Newark rank 75th of the 75 largest American cities. Unemployment was and continues to be substantially higher in Newark than in the remainder of the SMA and, even more significantly, substantially higher than national central city populations.

Over 33 percent of the population of Newark was under 18 years of age, compared to 26 percent in the rest of the SMSA; In fact, Newark's population has the lowest median age level of all major cities in the nation. Thirty-four percent of the population was living in a female headed household. There were 12,300 crimes per 100,000 residents. In the 1980 census, there were 78,000 Newark residents between the ages of 16 and 21.

In summary, Newark is the poorest City in the nation, has the lowest median age population, the lowest educational attainment level, and, per capita,'the most residents inpublic housing'.

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The State of New Jersey currently ranks fourth among all states in the total number of AIDS cases reported. Nationally, among Standard Metropolitan Statistical Areas (SMSAs), the Newark SMSA ranks fifth. According to the City

of Newark's Department of Health and Human Services, the City of Newark has substantially more than 20 percent of the reported AIDS cases in the State of New Jersey.

Baseline data about Newark's AIDS situation tends to be somewhat thin. (Published State data is organized only by County.) This produces a lack of clarity about the real City situation. The sketchy AIDS data for Newark, drawn from the State Health Department database (unpublished) indicates that:

1. Reported AIDS cases from 1985 through 1988 show that in 1985 there were 142 cases reported; in 1986 there were 227 cases; in 1987 there were 335 cases. The still preliminary and substantially incomplete data for 1988 shows to date a total of 343 cases.

2. AIDS deaths, by year of initial identification, were: 1985, 103; 1986, 138; and 1987, 193. Overall, since 1981, 56 percent of the 1194 cases officially reported in Newark have resulted in death (with much of 1988 data still to be recorded and reported).

   This means that there are more than 520 people diagnosed as having AIDS who are still alive in Newark. If trends continue, we anticipate an additional 350 cases or more in 1989 and about 700 survivors.

   Final directional trends of cases in Newark cannot be even reasonably estimated until the 1988 data collection and analysis has been completed.

   Newark, with less than five percent of the State's population, has consistently every year had more than 20 percent of the identified AIDS cases.

3. The age structure of these AIDS cases in Newark was: under five, four percent; five to twelve, less than one percent; 13 - 19, one percent; 20 - 29, seventeen percent; 30 - 39, fifty-one percent; 40 - 49, nineteen percent; and 50 and over, eight percent. Not surprisingly, the age cohorts of Newark A.I.D.S. cases (without including cases of inmates sentenced to State or Federal institutions, is lower than those of the rest of the State or nation.

The age data suggests the hypothesis that reduction of high risk behavior among youth and young adults would lead to a substantial reduction in AIDS cases among age groups with the highest incidence of such cases, especially given

the long incubation period (now estimated at up to 15 years). Thus a reduction in this behavior would have dramatic impact upon the long term growth of the HIV infected population.

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One means to possible AIDS prevention among adolescents is education stressing avoidance of some behavior patterns and certain prevention techniques,especially via counseling. Just as in the general population, there is tremendous misinformation and ignorance about AIDS among the vast majority of adolescents. Unfortunately, too many adolescents in Newark either do not have the opportunity to recieve AIDS prevention/education information, or, because of the lack of structure in their lives, traditional methods of providing such information just do not work. This is especially true of the target adolescent population of this plan.

Major barrigrs to the dissemination of relevant AIDS information to the target population are distrust of official institutions, fear, and the inner City low income sub-culture which, by its very nature, resists a planful approach. The distrust is exemplified by the school drop-out problem. To the drop-out, the school--representing the most obvious official institution--appears to be at worst rejective or at best unresponsive. The fear among Minority homosexual groups, we believe, is more than seems normative in the more middle class White homosexual populations. In addition, this is in large part a very low income population, which reflects the dismal social environment revealed by quantitative data about poverty, crime, violence, isolation, and family breakup. There is a 'culture of poverty' much like that described by the anthropologist Oscar Lewis but exagerated by drugs and disease. Thus, the unusually high rate of bisexuallity among youth and young adults in this population.

In addition, there is another significantly neglected population which has been touched by the AIDS epidemic but for whom there has yet to appear in Newark any targeted response. Specifically, organization of handicapped/ disabled persons and some agencies servicing these different persons have noted the recent spread of AIDS among their constituent groups but have yet to gain access to any materials specifically designed to meet their particular needs. Hence, our desire to work with those handicapped/ disabled adolescents who exibit high risk characteristics.

It should be noted that we have not seen even a preliminary assessment of the AIDS education effort in the school system - its success or failure. In fact, we are aware that to this date the Newark Board of Education has yet to name an AIDS education Coordinator or develop a

strategy for dissemination of AIDS curriculum materials, training of Teachers in the utilization of such materials, or appropriate follow-up procedures.

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Newark has a large population of young people (33% under age 18 compared to 26% in its own SMSA). The City has the lowest median age level of all major cities in the country.

In and of itself, this age structure might not necessarily be problematic. What is problematic is that so many of these young people can be described as: poor; dreadfully undereducated; unemployed (and, by some assessments, unemployable; and deeply affected by an environment of drugs, crime, and family breakup. In fact, Newark has a large young populace many of whom have weak or non-existent affective connections to normative social institutions. Thus, 'street' peer groups end up as becoming the major socializing influence. [For a good description of these youth, see attached article from 3 April, 1989 issue of 'Insight' magazine.]

As we know from acknowledged Census Bureau undercounts, it would be extremely difficult to determine with precision the size of this population. But certainly unemployment and educational data are indicative. The Regional Labor Market Review for August, 1988, indicated that in 1987 the City had a double digit unemployment rate of 10.7% (which all analysts agree understates the problem) while other municipalities in the County had unemployment rates below the state level. [Unemployment rates are particularly high and consistently so -- for young Minority males.]

Newark qualifies as a 'labor surplus' area by federal standards. Educational involvement data in the 1980 census indicated that 54 percent of people aged 16-21 were not in school. This compared with 23 percent in the remainder of the same SMSA.

The very description of this population explains why we cannot assume that health education information is being delivered effectively. <u>These young people simply have no history of affective connection with institutions</u>. In fact many institutions--whether schools, social welfare agencies, or police -- are perceived as hostile rather than potentially supportive.